

two-day course (with no hands-on training) by a dermatologist, which then enables them to prescribe the medical-grade skin products that are recommended by the course provider. Dentists are then selling the products and giving specialist skin care advice to patients and the public through social media platforms. This is often misleading for the general public as they appear to be specialist consultants, but as dentists we are not professionally trained dermatologists.

To be a dermatologist requires extensive training: five years at medical school, two years as a foundation doctor, two years of core medical training and then a three-year dermatologist training pathway. Skin care is outside the remit of a dentist and this should not be a service that we provide nor to mislead patients into thinking that they are receiving specialist skin advice and treatment. Personally, we would not be comfortable seeking advice and treatment

from someone who has been to a two-day course. Would you?

When beauticians were providing tooth whitening, we found this unacceptable and putting patients at risk; what is the difference here with dentists providing skin care? Being a dentist of course involves the facial region, however, this does not mean we can then take on anything that is part of the head and neck. What next? Ear, nose and throat treatment?

S. Jannati, A. Sanalla, London, UK

<https://doi.org/10.1038/s41415-020-2366-0>

Paediatric dentistry

Lego leverage

Sir, I refer to the letter to the *BDJ* published on 28 August 2020 entitled *Let it go – Lego!* (*BDJ* 2020; **229**: 212) regarding the hazards of small pieces of Lego. I am myself familiar with the offending piece of Lego shown in the photograph, having spent many an

hour building Lego kits myself. I must stress however, that my lower incisors have thus far been safe from the clutches of such a piece.

I thought readers may find it useful to know of the removal tool to which the authors refer. I believe the instrument in question is the Lego Brick Separator which can be acquired through the Lego shop but which is often included in larger sets of Lego as well.¹

As can be seen on the Lego website,¹ this tool can act as a lever but also has a small plus shaped fitting as well, mimicking the axel onto which such a wheel hub attachment can be slid. I believe either aspect could have been of assistance in the case detailed last month.

S. Lovel, Sunderland, UK

Reference

1. LEGO. Lego Brick Separator. Available at: <https://www.lego.com/en-gb/product/brick-separator-630> (accessed October 2020).

<https://doi.org/10.1038/s41415-020-2367-z>

CASE REPORT

Epidemiology

Oral tuberculosis

Sir, a 39-year-old Caucasian gentleman of Polish origin presented to our department with a non-healing ulcer of the tongue of three months' duration. The area was minimally tender and had not seen significant change in size after the initial growth. His past medical history was significant for 'self-diagnosed' anxiety for which he used diazepam obtained from his friends. He smoked 20–30 cigarettes along with cannabis and consumed 1 litre of vodka every day. He denied any recent foreign travel, fevers or night sweats. He had lost approximately 5 kg of weight in the past

three months which he related to not eating well due to a busy job.

On examination, he had no obvious palpable cervical lymphadenopathy. A 3 x 2 cm large indurated ulcer with rolled borders was noted on the right posterolateral aspect of the tongue suspicious for malignancy (Fig. 1). An urgent biopsy revealed ulceration and necrotising granulomatous inflammation with no evidence of dysplasia or malignancy. Magnetic resonance imaging demonstrated a 1 cm diameter enhancing lesion on the right lateral tongue with additional multiple necrotic nodes of ipsilateral level II/III region and contralateral level II region. Computed tomography imaging of the chest showed extensive 'tree in bud' nodularity with calcified granulomas and parenchymal fibrosis (Fig. 2). The patient was

referred to the respiratory team for further investigations and management. During the investigative period, the patient developed a productive cough along with dyspnoea. Sputum examination confirmed the diagnosis of tuberculosis (TB).

The patient was isolated and treated initially with quadruple therapy (rifampicin/ethambutol/isoniazid/pyridoxine) with pyridoxine for two months. On review after three months, there was symptomatic improvement and satisfactory healing of the tuberculous ulcer.

It is estimated that 10% of cases of extrapulmonary TB are found in the head and neck region and 10% of those cases present in the oral cavity.^{1,2} Early differentiation together with prompt multidisciplinary management prevents spread of this deadly disease.

S. Mumtaz, R. Pabla, London, UK

References

1. Srivanitchapoom C, Sittitirai P. Nasopharyngeal tuberculosis: epidemiology, mechanism of infection, clinical manifestations, and management. *Int J Otolaryngol* 2016; **2016**: 4817429.
2. Pang P, Duan W, Liu S *et al*. Clinical study of tuberculosis in the head and neck region-11 years' experience and a review of the literature. *Emerg Microbes Infect* 2018; **7**: 4.

<https://doi.org/10.1038/s41415-020-2368-y>

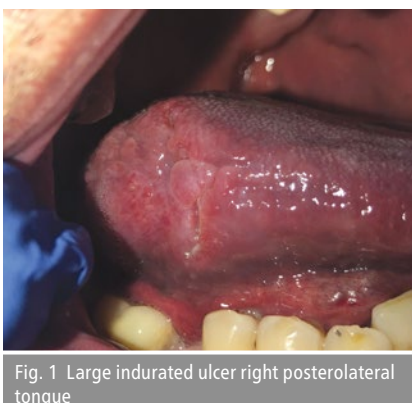


Fig. 1 Large indurated ulcer right posterolateral tongue

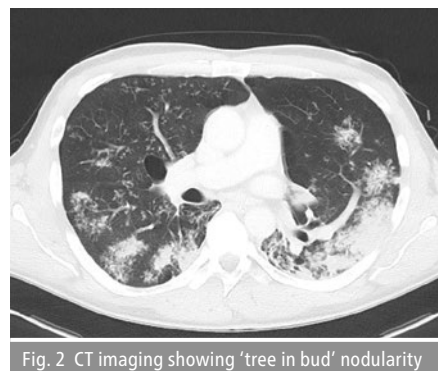


Fig. 2 CT imaging showing 'tree in bud' nodularity